STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G668	A. BUILDING 01 B. WING	09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	324 W MAIN ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/28/11 Facility Number: 008302 Provider Number: 15G668 AIM Number: 100235310 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Peak Community Services Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was not sprinklered. The facility has a fire alarm system with smoke	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	detection in corridors, sleeping rooms and common living areas. The facility has the capacity for 6 and had a census of 5 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.4. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/29/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0130	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply and transfer sites was provided with separation from any portion of the facility wherein residents are housed, by a fire barrier of 1 hour fire resistant rating. NFPA 99, Health Care Facilities, in Chapter	K0130	Peak Communitiy Services is commitied tio ensuring clienti safietiy and maintiaining compliance witih oxygen tiank safietiy Tanks have been ordered and delivered by tihe home healtih agency. The liquid oxygen tiank will be removed when tihe new systiem is in place. The Communitiy Services Manager and Residential Sitie Coordinatior will	10/28/2011

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	13, "Other" Health Care Facilities in 13-1 states, "this chapter addresses safety requirements for facilities, or portions thereof, that provide diagnostic and treatment services to patients in health care facilities other than hospitals, nursing homes, or limited care facilities as defined in Chapter 2. This deficient practice affects all occupants. Findings include: Based on observation with the house manager on 09/28/11 at 4:30 p.m., a 181 L capacity liquid oxygen supply tank stood in one corner of the dining room. The house manager said at the time of observation, one resident required oxygen. He usually had oxygen supplied per nasal cannula via an oxygen concentrator. The liquid oxygen tank was on hand to fill a portable oxygen tank and provide emergency oxygen for him if the power supply for the oxygen concentrator should fail. She said transfer into the portable tank was done in the corner of the dining room.		review safietiy issues on a montihly basis fior confiormance tio lifie safietiy codes. Stiafi responsible: Amanda Clapp, Sitie Coordinatior Kris Myers, Communitiy Services Manager Completion datie: 10/28/11	

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KS018	Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the non sprinklered facility failed to ensure 1 of 4 sleeping room doors would self close or automatically close upon activation of the fire alarm system. This deficient practice affects all clients, staff and visitors. Findings include: Based on observation with the house manager on 09/28/11 at 4:40 p.m., the self closing door to the back sleeping room was held open with a magnet which released the door upon activation of the fire alarm. The door failed to self close when released from the magnet and upon closer inspection it was noted the arm had been removed from the self closer. The door was opened wide	KS018	**K0018** Peak Communitiy Services is commitied tio ensuring clienti safietiy by maintiaining selfi-closure devices on all fire doors. The door in question has been repaired and now selfi-closes when tihe fire alarm is activatied All SGL residences operatied by Peak Communitiy Services will be maintiained in compliance witih all requirementis ofi tihe currenti Federal and Stiatie ICF/DD stiandards Routine maintienance should be done by SGL stiafi as much as possible. For maintienance tiasks tihati cannoti be accomplished by stiafi tihey should notifiy tihe Facilities Manager via tihe Maintienance and Custiodial Log on tihe Shared Drive Stiafi should also notifiy tihe SGL Manager. Major appliances will be maintiained by tihe Facilities Manager or tihrough a privatie contiractior ifi necessary. Any breakdown ofi major appliances should be reportied immediatiely tio	10/28/2011

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	and was not arranged to automatically close upon activation of the fire alarm system. The house manager said at the time of observation she was unaware the self closer had been dismantled.		tihe SGL Manager who will provide guidance in tihis area Stiafi Responsible: Ray Aldridge, Facilities Manager Amanda Clapp, Sitie Coordinatior Completion Datie 10/28/11	